**Prevention of Respiratory Syncytial Virus (RSV) with palivizumab (Synagis®) in high risk infants and children.** Specific information about national and regional RSV trends, especially pertaining to the peak variations in Florida and Alaska, is available from the National Respiratory and Enteric Virus Surveillance System (NREVSS) at: [http://www.cdc.gov/surveillance/nrevss/rsv/default.html](http://www.cdc.gov/surveillance/nrevss/rsv/default.html)

Please check all that apply to the individual:

- Please list individual's current age: ____________
- Please list individual's gestational age: ____________
- Please list total number of doses requested: ____________
- Please list total number of doses already given this RSV season and dates received: ____________

1. **Request is for** continued palivizumab (Synagis) prophylaxis treatment for a child who has experienced breakthrough RSV hospitalization.
2. **Request is for** palivizumab (Synagis) prophylaxis treatment of a child or infant with known RSV disease.
3. **Request is for** palivizumab (Synagis) prophylaxis treatment for a child or infant in the first year of life who is diagnosed with 1 or more of the following heart disease (CHD) conditions: 
(Please check all that apply)
- secundum atrial septal defect
- small ventricular septal defect
- uncomplicated pulmonic stenosis
- uncomplicated aortic stenosis
- mild coarctation of the aorta
- patent ductus arteriosus

4. **Request is for a maximum of five (5) doses of palivizumab (Synagis®) within the RSV season which begins during the first year of life.** (Please check all of the following that apply)
- Born before 29 weeks of gestation (up to and including 28 weeks, 6 days) and younger than 12 months of age at the start of the RSV season
- Individual has chronic lung disease (CLD) of prematurity (defined as birth at less than 32 weeks, 0 days gestation and required greater than 21% oxygen for at least 28 days after birth) (NOTE: Asthma, reactive airway disease and cystic fibrosis without significant symptoms do not meet the definition of chronic lung disease as per AAP Guidelines)
- Individual has hemodynamically significant congenital heart disease (CHD). (Please check any of the following that apply)
  - Individual has acyanotic heart disease and is receiving medication to control congestive heart failure and will require cardiac surgical procedures
  - Infant has moderate to severe pulmonary hypertension
  - Individual has anatomic pulmonary abnormalities of the airway (for example, tracheal ring)
  - Individual has neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough
- Other: ______________

5. **Request is for up to five (5) doses of palivizumab (Synagis®) prophylaxis for a child younger than 24 months of age with the following clinical presentations during the RSV season.** (Please check all of the following that apply)
- The individual is profoundly immunocompromised, such as severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, undergoing organ or hematopoietic stem cell transplant, or an absolute lymphocyte count of less than 100 cells/mm³; ( 
- The individual is undergoing cardiac transplantation

6. **Request is for an additional dose of palivizumab (Synagis®) prophylaxis for a child in an approved course of treatment** (Please check all of the following that apply)
- The individual has undergone cardiopulmonary bypass for surgical procedure
  - Cardiac or pulmonary hemodynamic support remains unchanged after surgery
  - Please describe any other medically necessary criteria (for example, prematurity).
    ______________
7. □ Request is for a second season of palivizumab (Synagis) prophylaxis for a preterm infant. (Please check all of the following that apply)
   - Infant was born at less than 32 weeks, 0 days gestation
   - Infant required at least 28 days of oxygen after birth
   - Infant continues to require the following medical interventions within 6 months of the start of the second RSV season (Please check all that apply)
     - Supplemental oxygen
     - Chronic systemic corticosteroid therapy
     - Diuretics
     - Bronchodilator therapy
     - Other medical intervention: ____________

8. □ Request is for palivizumab (Synagis) prophylaxis for an infant with cystic fibrosis in the first year of life (Please check all of the following that apply)
   - Infant has clinical evidence of chronic lung disease (CLD), defined as birth at less than 32 weeks, 0 days gestation and required greater than 21% oxygen for at least 28 days after birth) and is undergoing the following treatment:
   - Infant has clinical evidence of nutritional compromise, defined as weight for length less than tenth percentile. (Please provide the following information)
     - Height/Length: ____________
     - Weight: ____________

9. □ Request is for a second season palivizumab (Synagis) prophylaxis for a child diagnosed as having cystic fibrosis and has severe lung disease (Please check all of the following that apply)
   - Child has a history of hospitalization, abnormal chest x-ray or CT scan.
     - (NOTE: Please submit any chest x-ray and/or CT scan reports with your request)
   - Dates of hospitalization: ____________
   - Child is nutritionally compromised as demonstrated by a weight for length less than tenth percentile
     - Height/Length: ____________
     - Weight: ____________

10. □ Other Use(s) (Please describe and submit all supporting documents including labs, progress notes, imaging, etc., for review.)
    ____________

This request is being submitted:
□ Pre-Claim
□ Post–Claim. If checked, please attach the claim or indicate the claim number ____________

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

_________________________    ________________
Name and Title of Provider or Provider Representative Completing    Date
Form and Attestation (Please Print)*

*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.